Rhetoric or reality? A systematic review of the impact of participatory approaches by UK public health units on health and social outcomes

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ABSTRACT

Background There has been a philosophical commitment to participation in public health since the 1970s. UK policy rhetoric on participation in public health has been particularly marked since 1997. It is less clear that participatory approaches have been pursued by UK public health units in practice.

Methods A systematic review was undertaken of all studies using any recognized research methodology from 1974 to 2007 reporting on health and social outcomes of participatory approaches by UK public health units. Seventeen electronic databases were searched and inclusion/exclusion criteria and quality appraisal criteria applied.

Results Five thousand and four hundred and fifty-one references were identified, reduced to 2155 once duplicates were removed. Only eight papers covering seven studies were relevant and included in the analysis. Only two studies met more than half of the relevant quality appraisal criteria. The studies fell into two distinct groups: four used qualitative methods to illustrate the complexities of effective community participation; three claimed success for their participative initiative without providing adequate evidence to substantiate such claims.

Conclusions This systematic review demonstrates that there is very little evidence in the peer-reviewed literature of participatory approaches by UK public health units or of such approaches having any noteworthy impact on health and social outcomes.

Keywords communities, public health, research

Background

Since the 1970s the overlapping concepts of community development, engagement, involvement and participation (hereafter called participatory approaches) have become a central concern of the international public health movement. Stimulated in part by the declaration of Alma Ata,³ the Ottawa Charter⁴ and the concepts of ‘health for all’ and ‘healthy communities’, the public health system in the UK has also demonstrated an increasing rhetorical commitment to participatory approaches. Participatory approaches are now mandated in government public health policy pronouncements,³,⁴ required in the local implementation of public health initiatives such as Health Action Zones, Sure Start and Healthy Living Centres, included in professional competency frameworks and standards⁵ and regularly commended in national guidance⁶ and in public health textbooks.⁷

However, it is less clear that participatory approaches have been regularly pursued by UK National Health Service (NHS) public health units in practice. The NHS public health function has continually evolved since its transfer
from local government in 1974. Over this period successive NHS re-organizations have seen the ebb and flow of two key NHS public health organizational units: departments of public health which were traditionally staffed by medically qualified consultants in public health and responsible for population needs assessment, commissioning and evaluation of health services and (until 2003 in England) health protection; and health promotion units with more diverse responsibilities but often including community development, partnership working, primary prevention initiatives and campaigns. Although there has always been a great deal of variation in both nomenclature and structure, often health promotion units have been organizationally accountable to (and had lower status than) departments of public health. Since 1997, the UK government’s policy of devolution has meant that there has been increasing structural and policy diversity between the four UK jurisdictions of England, Scotland, Wales and Northern Ireland. In England the NHS reorganization of 2001–02 led to the disaggregation of health authority public health departments into smaller primary care trusts and often the re-integration of public health and health promotion units. The recent emergence of multidisciplinary public health challenging medical dominance has led to revisions to professional competency frameworks and standards which include recognition of the need for public health specialists to have skills in participatory approaches.

A preliminary scan of the UK public health literature demonstrated that there was some empirical research on community development in UK public health settings, but this literature has never been systematically reviewed or synthesized. A number of related literature reviews have covered participatory approaches in international health promotion and health planning, the evidence on effectiveness of empowerment to improve health, the evaluation of community-level interventions for health improvement in the UK, what works in community involvement in area-based initiatives and community engagement to improve health. But there has been no systematic review specifically on the impact of participatory approaches by UK NHS public health units. This systematic review addresses that gap in the literature.

The preliminary scan of online databases indicated that there were some relevant empirical research articles in the literature, but few, if any randomized controlled trials; the initial literature found was largely qualitative. Thus this systematic review builds on the emerging methodology of qualitative systematic reviews, which has been used in previous systematic reviews co-authored by the lead investigator.

**Methods**

The key question addressed by this systematic review was: what has been the impact of participatory approaches by UK NHS public health units (including health promotion units) on health and social outcomes? The search strategy to address this question involved searching 17 relevant electronic databases (Box 1) with four word groups (Box 2) for the period 1974 to 2007. The four word groups (population, intervention, organizational setting and outcome) were combined with ‘AND’ between word groups and ‘OR’ within word groups. This search period covered the time from transfer of public health from local government to the NHS in 1974 and ended at the time the review began in 2007. The word groups were identified through a pilot process from October to December 2007 to ensure maximum coverage balanced with a manageable hit rate. In addition four public health journals with significant UK orientations (Critical Public Health, Health Education Journal, Health Promotion International and Journal of Public Health) were hand searched. Finally, the reference lists of the NICE guidance on community engagement and the reviews conducted for it were scrutinized for possible additional references. Inclusion and exclusion criteria were identified (Box 3). Due to the resource constraints of conducting a non-funded systematic review, only peer-reviewed literature and not grey literature were included. Electronic searching was conducted by a library specialist with previous systematic review experience. Electronic and hand searching was completed by August 2008 and all references were downloaded into a RefWorks database for further processing.

**Box 1 Electronic databases searched**

- AMED
- ASSIA
- BHI
- BNI
- Campbell collaboration
- CINAHL
- Cochrane library
- Community wise
- Medline
- Embase
- HMIC
- IBSS
- PsychINFO
- SCI
- SSCI
- Social care online
- Sociological abstracts
Box 2 Word groups

<table>
<thead>
<tr>
<th>Word group 1 (population)</th>
<th>Word group 2 (intervention)</th>
<th>Word group 3 (organizational setting)</th>
<th>Word group 4 (outcome)</th>
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<tbody>
<tr>
<td>Citizen*</td>
<td>Alliance*</td>
<td>Community medicine department*</td>
<td>Case study</td>
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<td>Communit*</td>
<td>Collabor*</td>
<td>Community medicine directorate*</td>
<td>Case studies</td>
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<td>Community medicine organisation*</td>
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<td>Disadvantage*</td>
<td>Empower*</td>
<td>Community medicine team*</td>
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<td>Ethnic*</td>
<td>Engag*</td>
<td>Community medicine unit?</td>
<td>Changing</td>
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<td>Hard to reach</td>
<td>Involv*</td>
<td>Department* of community medicine</td>
<td>Consequences</td>
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<td>Lay</td>
<td>Participation</td>
<td>Director of public health</td>
<td>Decision making</td>
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<td>Marginali*</td>
<td>Participative</td>
<td>Directorate* of community medicine</td>
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<td>Minorit*</td>
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<td>Health promotion department*</td>
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Titles and abstracts of initially identified references were assessed independently by two reviewers (DE and PP) to identify those studies likely to meet the inclusion criteria. Provisional lists were discussed and agreement made on articles for full text retrieval. Once full texts were retrieved, these were processed using a data extraction form developed for previous systematic reviews. Inclusion and exclusion criteria were again independently applied by DE and PP and a final list agreed of included studies for quality appraisal. The reference lists of included studies were also scrutinized for possible further relevant studies but none were identified.

Two reviewers (DE and PP) independently assessed the quality of the studies against the criteria developed by Smith and colleagues from the CASP criteria and other sources (Box 4). Given the primarily qualitative nature of the final studies, a simple narrative analysis was carried out.

Results

The results of the search are illustrated in Figure 1. 5,451 references were initially identified which reduced to 2,155 once duplicate references were removed. Sixteen papers were independently selected by one or both of the reviewers as possibly meeting the inclusion criteria. Following joint re-examination, eight papers were agreed to meet the inclusion criteria, with two papers relating to one study, so
seven studies were included in the next stage of quality appraisal. Included studies are summarized in Table 1.

**Methodological characteristics of the studies**

There was a fair degree of methodological heterogeneity across the seven studies. Four of the studies were qualitative, whilst three were mixed qualitative and quantitative. In two studies semi-structured interviews were utilized, whilst one used both semi-structured interviews and focus groups. One study used a mixture of four qualitative methods: a ‘cobweb’ exercise, discussions and questionnaires with three interest groups, four residents’ workshops and an evaluation diary. Three of the studies did not describe their qualitative methods in sufficient detail to categorize or assess them. In terms of the quantitative element of the three mixed method studies, two used postal questionnaire surveys and one involved analysis of routine data.

**Quality appraisal**

The quality of the seven studies was generally poor when tested against the appraisal criteria. Only two of the studies met a majority of the 10 qualitative criteria (seven out of 10 in each case). For the qualitative studies (and the qualitative elements of the mixed methods studies), the methods were generally well described in two cases, only partly described in two further studies and not well described in the final three studies.

With regard to the three mixed methods studies, the quantitative elements were limited to two descriptive surveys and one analysis of routine data; thus none of the mixed methods studies met more than two of the quantitative criteria. The studies were generally poor in providing methodological detail around recruitment strategies and sampling. None of the studies met the criteria relating to consideration of the limitations of the study or reflexivity. The failure to
meet these criteria is particularly significant as none of the authors appeared to be wholly independent of the public health units undertaking the interventions the authors were assessing. In the one case where an academic unit was externally funded to carry out an apparently independent evaluation of an intervention, the lead author had moved to the academic unit from the public health unit where she had previously been involved in delivering the intervention.26/27 

As only two studies met the majority of the relevant quality criteria, it was not feasible to do a thematic analysis across only quality assured studies. We therefore present results for all seven studies but qualify our discussion where appropriate with respect to the variable quality of our sample.

**Populations**

The populations that interventions were directed towards were geographically defined in six of the seven studies. Three of the populations were large in scale (one Scottish region and two major English cities) whilst three were at the neighbourhood, ward or estate level in English or Scottish cities. The seventh study population was defined by ethnicity (South Asian) within a major English city. However, the samples of the populations involved in the research were well described in only two of the seven studies.

**Interventions**

In five of the seven studies the intervention being assessed was a community health development initiative; in two cases these were topic specific (heart health in one case, tackling smoking in the other) whilst three were more generic. The final two interventions were the development of city-wide public health strategies.

**Organizational settings**

The organizational location and disciplinary background for the public health workers with responsibility for implementing the participatory approaches were not well described. In several cases the disciplinary background of the worker could only be deduced from the lead authorship of the published paper. In five studies, the lead author and apparent lead worker came from health promotion backgrounds, whilst in one case they were a specialist registrar in public health. In the final paper authored by two academics apparently independent of the intervention, the NHS lead for the intervention was not specified beyond a collective ‘Joint Public Health Team’. The boundaries between public health and health promotion units are of course blurred in the UK, and became more blurred following the emergence of multidisciplinary public health in the 1990s. However, as far as can be identified, it appears that the interventions were led in the majority of cases by those from health promotion rather than public health backgrounds. It is also notable that only one of the eight papers appeared in a journal with a ‘public health’ label as opposed to seven which appeared in journals with a ‘health promotion’ orientation.

**Outcomes**

Only one of the seven studies sought to make any assessment of the impact of the intervention on measurable health outcomes. Ewles and colleagues22 compared routine data on a range of indicators (e.g. lone parent families, unemployment rates, families on low incomes, families where at least one parent smoked, rates of premature death) before and after the community health development initiative. However, the authors themselves draw attention to a number of limitations to their data and analysis including that they are unable to determine how much of the change in outcome indicators can be attributed to the initiative and how much was due to wider changes in the community. Moreover, there was no use of a control population. Two
other studies\textsuperscript{23,25} indicated that outcomes would be measured and reported in the future, though no further peer-reviewed papers reporting such assessments have been identified. One mixed methods study\textsuperscript{25} was able to demonstrate a high level of awareness of the initiative in the community. Four of the studies (including our two highest quality studies) reported qualitative data on the process of participation and community participants’ perceptions of the quality and impact of such participation.\textsuperscript{21,24,26–28} All four of these studies identified barriers and concerns from community participants over their ability to effectively influence decision making. Common issues included power inequalities between communities and professionals, exclusionary professional language, time and resource constraints, and community scepticism that they could really influence professional/organizational decisions. The authors of three studies made claims for the success of their initiatives without providing any robust evidence to justify these claims of success.\textsuperscript{22,23,25}

Discussion

Main findings of this study

The main finding of this study is that there is very little evidence in the peer-reviewed literature of participatory approaches by UK public health units or of such approaches having any noteworthy impact on health and social outcomes. A conclusion of a lack of evidence is a common one in systematic reviews, and although possibly frustrating for the reader, does at least provide a firm empirical basis on which to consider our knowledge base for important policy questions as to the extent to which policy rhetoric is matched by practice on the ground. In this review, only seven studies met our inclusion criteria from amongst the thousands of UK-originated studies in the peer-reviewed international public health literature. Thus this study demonstrates that the evaluation of participatory approaches within UK NHS public health has not been a priority for UK public health research. For those few relevant studies we found, study quality was generally poor, with common

\begin{table}[h]
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\begin{tabular}{|l|l|l|l|l|l|l|}
\hline
Papers & Study intervention & Population (Community in study sample) & Design/methods & Study results & Qualitative critical appraisal\textsuperscript{a} & Quantitative critical appraisal\textsuperscript{b} & Reviewer comments \\
\hline
Bandesha & Asian health development project & Local South Asian community (n = 14) & Qualitative interviews, focus groups & Community felt professionals kept control & 1,2,5,10 & N/A & Lack of methodological detail but plausible analysis \\
Litva (2005)\textsuperscript{21} & & & & Identification of ‘successful’ activities & & & Data do not support claims of success \\
Ewles et al. (2001)\textsuperscript{22} & Health and environment action group & Estate population (n = not stated) & Routine data, plus unspecified qualitative & & 1 & None & \\
Halliday & Consultation on public health strategy & City population (n = not stated) & Qualitative, but no formal design described & ‘Successful’ consultation & & N/A & Data do not support claims of success \\
& (1992)\textsuperscript{23} & & & & & & \\
& & & & & & & \\
Hamer & Network for change & Ward population (n = 45 + ) & Qualitative mixed methods & Residents perceived views not reflected & 1,2,4,10 & N/A & Lack of methodological detail but plausible analysis \\
& & Regional population (n = not stated) & Survey, future plans described & High awareness, list of ‘successful’ initiatives & & & Survey results on awareness only; data do not support claims of success \\
Macallan & Heart health campaign & & & & 1,2 & N/A & \\
& & & & & & & \\
Ritchie & Community based smoking intervention & Neighbourhood (n = not stated) & Qualitative interviews & Community did not feel parity of participation & 1,2,4,5,6,7,10 & N/A & Some gaps in methodology but overall convincing \\
(2001)\textsuperscript{26} & & & & & & & \\
Ritchie et al. (2004)\textsuperscript{27} & & & & & & & \\
& & & & & & & \\
Strobl & Consultation on public health strategy & City population (n = 680) & Qualitative interviews, survey & Mixed views on effectiveness of consultation & 1,2,3,4,6,7,10 & 1 & Some gaps in methodology but overall convincing \\
& (2000)\textsuperscript{28} & & & & & & & \\
\hline
\end{tabular}
\caption{Summary of included studies}
\end{table}

\textsuperscript{a}Numbers in this column signify the quality criteria from Box 4 that the studies were deemed to have met.
problems of un-evidenced assertions of success and a lack of methodological detail. Only one of the studies focused on health outcomes, and its assessment of outcomes was rightly heavily qualified by the authors. The other six studies focused on process indicators and issues, in particular the qualitative perceptions of community participants about the quality and impact of their participation. In two cases there were promises of future reports on outcomes, but these outcome assessments were not found in the subsequent literature.

**What is already known on this topic**

The barriers to community participation in UK public health identified in four of our included studies are similar to the barriers to participation extensively documented in the wider community participation in health literature. But previously, very little was known on our specific question of the extent and impact of participatory approaches by UK public health units. There is no previous systematic review on the subject, nor even any commentary or opinion piece discussing the gap between rhetoric and reality that we have identified. There are numerous general reviews on participation in health, detailed evaluations of related public health initiatives and the helpful recent NICE guidelines, but little of the material drawn on for these reviews and guidance comes directly from UK NHS public health practice.

**What this study adds**

This study adds to the literature on participatory approaches in public health the policy relevant finding that there have been few robust published studies of participatory approaches by UK public health units. This scarcity of empirical studies demonstrating outcomes from participatory approaches in UK public health is policy relevant because of the philosophical and rhetorical commitment to participation from UK public health policy makers and professional leaders. If participation is as important to public health as the policy documents and textbooks claim, then we need to ask ourselves why it is not better reflected in the UK public health research literature.

**Limitations of this study**

A key question is whether the identified gap between the rhetoric and reality of participative approaches by UK public health units is real or an artefact of our study. As Smith and colleagues have reflected in terms of their systematic review on public health partnerships, ‘searching for studies on public health interventions is difficult and time consuming, and the search strategies can often suffer from a lack of specificity.’ Our search around participatory approaches faced many of the same difficulties they identify in relation to their search on public health partnerships. In addition, we faced the additional limitation that our systematic review was not externally funded, and therefore time and resources were severely constrained. The biggest impacts of our resource constraints were that we were unable to include and review the grey literature. This might be seen to be a significant limitation, particularly given that much participatory work has been done in NHS health promotion units which do not have the same tradition of peer-reviewed publication as exists in more academically inclined NHS public health units. However, if we had included such grey literature from the health promotion field, it is likely that any additional material we identified would have had similar limitations in terms of quality to those published papers we found from health promotion practitioners. Furthermore, we would argue that a specific focus on the peer-reviewed literature is appropriate for this review, both because it is the first review on the topic and so is opening up a new area for scholarly investigation, and because there is value in demonstrating how little evidence on the topic has appeared in the most highly valued form of public health knowledge.

Finally, we recognize that participatory approaches engaged in by NHS public health units are only a small part of a much wider movement for community participation in health, and that our results need to be understood in the context of the much more extensive evaluative literature on community participation in health. This wider literature on community participation recognizes the challenges of trying to assess outcomes around such a complex social process which does not fit easily into classic evaluative designs (and randomized controlled trials in particular). Although we have found no review with a similar topic focus to ours in this wider literature, our findings are consistent with the conclusions on the complexity of such assessments, on the importance of context and on gaps between official rhetoric and community participatory experience on the ground.

**Conclusions**

This study has highlighted an apparently extensive gap between the rhetoric and the reality of participative approaches by UK NHS public health units. There is a strong UK policy commitment to participation in public health and extensive guidance (from NICE and other recent reviews) for the NHS on how to engage communities. By contrast, our systematic review has shown that...
there is very little evidence for the existence and impact of such approaches by NHS public health units in the published peer-reviewed literature. How then do we account for this apparent gap between rhetoric and reality? It is possible that the apparent gap is an artefact of our study limitations (particularly our lack of inclusion of the grey literature), that we have missed some important studies due to the limitations of our methods, but this seems unlikely to account for the extent of the paucity of relevant peer-reviewed studies in our findings. An alternative and plausible explanation is that such participatory approaches are rare in UK NHS public health practice. But the occasional reference to relevant grey literature in the reference lists of our included studies, and our personal experiences of NHS public health over the last 20 years, suggest that there is much more such activity than has reached the peer-reviewed literature. A third alternative, and the scenario that seems the most likely to us, is that there is much more extensive participatory work by NHS public health units in practice, but that for a variety of reasons, these have not been subject to robust evaluative studies or written up in journals. Reasons for this may include that such participatory approaches are more likely to be undertaken by health promotion practitioners than by public health specialists, with the former being generally less academically qualified, having less of a research culture and less well linked to and supported by academic units. Moreover, participatory approaches are by their nature complex and changing, and so not particularly easy to evaluate with conventional evaluative designs. Finally, as Strobl and Bruce²⁸ found, there are no obvious sources of funding for such evaluations and obtaining funding can be a time consuming and fruitless endeavour. Without additional research to specifically explore the research culture and practice in NHS public health, we can only speculate on the relative impact of these possible factors shaping research and evaluation on community participation. Thus, if the NHS and its partners are to truly value evidence-based practice in community engagement to improve health, as exemplified by the recent NICE guidance, then public health researchers and research funders need to prioritize and resource evaluative studies to assess the quality and effectiveness of participatory approaches by NHS public health units in practice.

Acknowledgements

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References


